This form may be completed online, printed and mailed to the address listed below.

07-12-04 **APPLICATION FOR NURSE AIDE REGISTRY FOR INTERSTATE ENDORSEMENT**

This application is required to implement programs authorized by sections 1819 (f) and 1919 (f) of Public Law 100-203, the Omnibus Reconciliation Act of 1987. Although you may refuse to supply the information requested below, failure to provide requested information may result in denial of your request to be placed on the registry. The data supplied becomes part of your permanent file which is a public record.

Please type or print clearly, attach copies of any certificates or wallet cards you have, and forward this application to the address or fax number below. If you were initially trained in Iowa, you must also attach a photocopy of the actual certificate you received to prove you successfully completed a 75-hour course. We will contact the Nurse Aide Registry in the state in which you received your training and any other states in which you have done nurse aide work. Since applications are processed in the order received, it normally takes about two weeks to process your application. We do not issue licensure cards for Nurse Aides. We will send you a screenprint from our website once it has been issued. You may check the website which is updated nightly at: www.hhs.state.ne.us./lis/lisindex.htm

1. NAME: _____
(Last) (First) (Middle)

_____
(Maiden) (Other previously used last name or names)

2. MAILING ADDRESS: _____
(Street) (Apt. #)

_____
(City) (State) (Zip Code)

3. TELEPHONE NUMBER: _____ 4. SOCIAL SECURITY #: _____

5. DATE OF BIRTH:_____ 6. PLACE OF BIRTH: (city/state) _____

7. TRAINING:_____
(Name of **Initial** Training Course Completed)

_____
(Initial Course Sponsor) (Total Number of Course Hours)

_____
(City/State of **Initial** Course Sponsor) (Course Completion Date)

8. STATE ORIGINALLY APPROVED:_____ 9. DATE APPROVED _____

10. REGISTRATION CERTIFICATION NUMBER (if applicable): _____

11. LIST ALL OTHER STATES IN WHICH YOU ARE APPROVED:

STATE	DATE APPROVED	REGISTRATION OR CERTIFICATION #

12. Have you been employed as a nursing assistant during the past 24 months? YES ___ NO ___

13. Please list employers who can verify your employment during the past 24 months. These employers may be contacted for confirmation at the discretion of the Division.

NAME OF EMPLOYER	ADDRESS	PHONE #	DATES WORKED (MONTH/YEAR) FROM:	TO:

14. I hereby authorize the Department of Health & Human Services to request information regarding my nurse aide registry status from the states identified in #8 and #11.

_____
Applicant Signature

_____
Date Signed

Return this form to:

DEPT. OF HEALTH & HUMAN SERVICES
REGULATION & LICENSURE CREDENTIALING DIV.
P. O. BOX 94986, LINCOLN, NE. 68509-4986

Phone (402) 471-4971 **Fax (402) 471-1066**